DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

MENTAL HEALTH RESIDENTIAL TREATMENT COST REPORT EXEMPTION FORM

Cost Report Due Date: JANUARY 31, 2007

PLEASE COMPLETE AND SUBMIT IF EXEMPT

This completed form MUST be submitted in order to request exemption.

Federal Tax ID:_____ ***REQUIRED**

Corporate Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Medicaid Provider Numbers: _____ _____

_____ _____ _____

_____ _____ _____

Please attach additional sheets if more Medicaid Provider #s are needed.

We are requesting exemption from the 2007 Mental Health Residential Treatment Cost Report due to: [Indicate appropriate reason/s]

_____ was not in business for **at least 6 months** in the reporting period.

_____ will submit the **Residential Treatment and Foster Care Cost Report** due March 15, 2007 to the DHHS, Office of the Controller.

_____ filed or will file the **2006 Mental Health Cost Report** to the DHHS, Office of the Controller.

_____ does not meet the Medicaid minimum dollar threshold of **$230,000** per Agency **Federal Tax ID#** in revenue generated from providing Medicaid Residential Treatment Services. This threshold has been established based on cumulative revenue by Tax ID. For multi-facility agencies, combine the revenue for all individual facilities to determine if you meet the minimum dollar threshold.

_____ _____
(Date) (Signature of the Provider Agency)

_____
(Printed name of person signing above)

Return completed form via email, fax, or mail to:
N.C. Division of Medical Assistance
Attention: Deidra Oates
Financial Operations
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: (919)715-2209
Email: deidra.oates@ncmail.net